Ask the Administrator Panel

March 28, 2016

PROGRESSIVE eSupport
LIFE SUPPORT FOR YOUR ASC

www.progressivesurgicalsolutions.com/esupport

to everyone who submitted questions
and for those who were able to join us for the LIVE webinar!
20 minutes wasn't nearly enough time…so, as promised
we have more answers to your burning questions in this PDF.

If you missed the webinar, you can view it here!

QAPI

Q What is the proper flow of a QAPI meeting?

A Remember that the QAPI meeting should be the summary and presentation of data that has been collected from your quality activities for a given quarter. Included should be any discussion and action taken from these activities. It's important to have a consistent agenda for your meetings to ensure you consistently include all items. Don't wait until right before the meeting to develop an agenda. If you are an eSupport subscriber, please go to *eSupport_Operations_Quality Management_Meeting Agendas/Minutes Examples*. If you are not an eSupport subscriber, there is a sample agenda attached at the end.

SURVEY

Q We're expecting AAAHC Medicare Deemed Status inspection within the next 2 months and want to know of any new, targeted areas from other ASCs?

A This is difficult to fully answer without knowing more about your facility. However, there are broad-brush items you can review to work toward survey readiness. Be sure you are aware of the regulations and standards and identify your own gaps since everything must be complied with. You should compare your practices to the CMS interpretative guidelines (*eSupport_Compliance_Regulations_CfC overview*), your state licensing regulations and the AAAHC handbook. Read each item to ensure you can respond to the standard or regulation. Perform the Infection Control Surveyor Worksheet by CMS. This is the exact form that the surveyors will be using. It is very helpful if you are familiar with the requirements and can speak to the surveyors from a similar level of interpretation.

Review your report from your last survey to ensure you have corrected any outstanding items.

The environment is a huge area of focus. Be sure to have your reports for utility maintenance (HVAC PM, air balance report, med gas manifold maintenance, generator testing and PM, etc.) available. Have a qualified person examine your firewalls for penetrations and seal those prior to your survey. AAAHC has the physical environment checklist, which I would recommend you complete to ensure compliance. For eSupport subscribers, go to *eSupport_Compliance_Life Safety Code* for additional resources and information. Bill Lindeman, who literally wrote the book on the Physical Environment Checklist for AAAHC, has provided essential information for your reference.

Credentialing remains a key area of deficiency. Ensure your processes are compliant with

A requirements and check each file for completeness. AAAHC has a worksheet in the back of their handbook that you can use for this purpose. Medication management is typically an area of focus and deficiency. Be sure that you use any medication that you draw out of its original container within one hour. Be sure you label all MDVs appropriately and that single use vials are for single use only.

Infection control remains an issue. As mentioned above, perform the IC survey at your facility to look for gaps in your practices. Make sure your staff members are donning masks appropriately (no hanging around neck), not wearing street clothes under scrubs and are performing appropriate hand hygiene. Ensure you are using your surface disinfectant per manufacturer's recommendations. Have PPEs available for staff in decontam, and make sure they are using them. Be sure to measure the amount of enzymatic cleaner that the manufacturer recommends. Gather DFUs for cleaning and care of your instruments. QAPI activities are a focus. For AAAHC, the specific aspects of a QI Study are important to include. There is a good description of what they are looking for in the back of the handbook.

Last, but not least, AAAHC provides a source for you. Follow this link and complete the request form to learn their standards with the highest deficiencies for Medicare deemed status facilities: http://www.aaahc.org/en/institute/Quality-Roadmap/

In summary, everything is important. If are an *eSupport* member, and you have a particular question about a specific item, I encourage you to ask questions on the *eSupport forum*. In addition, please check out *Survey Watch*, review *updated Policies/Procedures*, and review the *Quality Management Section* and other areas on *eSupport* that will assist you with compliance.

PSS consultants can conduct a mock survey, as well. Let us know if you would like more information on this (info@pss4asc.com).

STAFF EDUCATION

Q Does CMS, or any accrediting agency specify which topics are required annually for in-service education? What are they? Where could I find a list?

A Staff education is required and listed throughout regulations and standards, but there is not one concise list. Following is the list we use for clients, based on CMS and accrediting body requirements. Please be sure to check your state regulations to determine if there are additional items.

- Abuse Identification and Reporting (state and accrediting body specific)
- Infection Control
- Disaster Plan

- OSHA, including bloodborne pathogen
- HIPAA
- Fire Safety
- Hazard Communication
- QAPI Program
- Mock Code
- Mock MH, if triggering agents are used in your facility
- Anything specific to your organization, such as radiation safety and laser safety

Ensure your staff have these trainings upon orientation and annually in addition to drills for Fire, Disaster, Mock Code and Mock MH. Please note that AAAHC has a specific calendar requirement for when drills are conducted.

Q Do you have any recommendations for good educational materials on sterile processing for new personnel?

A If you are an eSupport subscriber, there are modules found at *eSupport_Continued Education_CE Contact Hours* that your staff can complete (licensed staff will receive a CE Contact Hour Certificate). In addition, you can go to well established sites such as APIC.org, AAMI, or 3M. Another reference specific to SPD is http://www.spdceus.com

Q What are the mandatory educational topics needed to maintain compliance with CMS and DOH in NJ? I am talking about the educational component for the medical staff physicians.

A Please see the above answer for suggested inservices for CMS. You don't mention an accrediting body, so you may need to alter this list based on your accrediting body. Your state provides regulations to you through a system called Nexis

There is a free site and a purchased site. You should make sure you have a current copy of the regulations at your facility.

In the ASC regulations, I could not see that medical staff was specified but they are in the hospital regulations. Please contact the state for clarification on what physicians need in the way of orientation and annual inservices.

Your employees need the following:

- Emergency Plans and Protocols
- Infection Prevention and Control
- Universal Precautions
- Patient Rights
- Child Abuse/Eder Abuse as applicable to your population
- Sexual abuse and domestic violence
- QAPI Program and Activities
- Policies and Procedures

CREDENTIALING

Q What is/are the process/steps/requirements for re-credentialing physicians at the ASC?

A Begin the reappointment process 90 days prior to expiration of appointment to ensure you have time to verify credentials and obtain Board approval for the reappointment. Any lapse in this timeline requires loss of privileges and a new appointment process.

While similar to the initial appointment in terms of time and process, there are items that you do not need to obtain. Those include:

- Peer References since you are using peer review
- Full application since you have already checked education/certification. Keep in mind you will need to obtain education data and proof of education was acquired during the appointment time that is pertinent to the privileges requested.
- Confidentiality statement
- Orientation, unless annual training is required

You still need:

- Short application, as mentioned above. You will want to obtain any new information, such as demographic information.
- Liability Questionnaire
- Health Statement
- Privilege request list
- Verification of hospital privileges
- Verification of credentials (Medical License, DEA, CDS if applicable). Keep in mind that any expirations should be verified during the appointment process and should not wait until reappointment.
- Verification of Board status
- Current CPR, BLS, ACLS and PALS, per your facility policy
- Current TB Testing and vaccinations are current, per your facility policy or state requirements
- Use of Peer Review in the reappointment process

Q What do you have surgeons do for Peer Review of non-incident charts? Can staff do some of this preliminarily when chart audits are done?

A Random chart audits should be performed for non-incident peer review. A standardized form should be used to eliminate bias and ensure everyone is reviewed to the same standards. Sample forms for surgeons and anesthesia providers can be found on *eSupport_Operations_Quality Management_Peer Review*. CMS and accrediting bodies are not prescriptive on the % or number of charts that should be reviewed. The number should reflect the types of cases performed at your facility. The only items non-medical staff should complete are demographic items, such as MR #, diagnoses and surgical procedure.

Q Can the Medical Director perform all the Peer Reviews, including his own? How many charts should we review for Peer Review? We do 5% and complications.

A The Medical Director cannot perform all peer review. Even if the Medical Director is the only physician in a single owned ASC, he/she needs to locate a physician who agrees to perform peer review for him/her. If there is no one locally to use for this (due to politics or the type of specialty), an outside company needs to be engaged.

As stated above, CMS and accrediting bodies are not prescriptive on the number of charts reviewed. 5% is commonly used and is fine.

HUMAN RESOURCES

Q What is the best way to handle a surgeon that yells at my staff and puts them in tears? This happened, and oddly enough, it was the last day for this surgeon at our facility. But for the future, how is this best handled?

A Our recommendation is to utilize your Medical Director for issues such as this. This type of behavior should be dealt with immediately as it creates a hostile work environment. There is ample documentation in the literature that shows this

A environment can lead to errors, which we certainly want to prevent. Sometimes, all it takes is a conversation with the Medical Director to stop the behavior from continuing. If the Medical Director is unwilling/unable to deal with the issue, take the issue to whichever body that your organization uses to perform peer review. This may be your Peer Review Committee, Medical Executive/Advisory Committee or Governing Body, depending on how you are structured. The peer review function can do more than mere documentation review and should be utilized to deal with this type of behavior. Your bylaws should have stipulations for fair treatment and hearings, should the behavior continue to escalate.

Q Does instrument tech need to have CPR?

A CMS mandates that only one person has CPR certification and accrediting bodies require an individual to be trained in ACLS and PALS, if you perform procedures on pediatric patients. Above that, it is up to your individual facility policy unless your state requirements differ from this. That being said, standard of care is to have everyone BLS certified and your licensed staff ACLS certified.

Q What are some resources for Human resource issues?

A The NLRB (National Labor Relations Board) provides a large amount of information for you. In addition, we are providing the following educational opportunities related to HR: Huddle on 5/23 - Top Ten Supervisor Slip Ups and Halftime 8/26 - Discrimination & Harassment

MEDICATION MANAGEMENT

Q Is prep solution considered a medication and should we be labeling prep sets after transferring prep solution, i.e. betadine from its original container to the prep tray? This was mentioned during a recent TJC survey.

A If your prep solution is used immediately and then discarded, it does not need to be labeled. If the solution was used over the course of a procedure or if it was opened and prepared prior to use, then it would need to be labeled.

Q One of our surgeons wants to disinfect Toric markers with Alcohol between patients? What is your opinion?

A Toric markers touch the eyeball. They must be disinfected and sterilized per manufacturers DFUs.

Q We have contracted CRNAs. Is it acceptable for the contracted CRNA to do the narcotic count and Diprovan count with a staff nurse and sign the narcotic log?

A Regardless of the status of the CRNA, they should not perform a count. This is not a specific regulation (unless it is in your state) but diversion activities are highest among anesthesia providers. We are certainly not inferring this is occurring in your case, but the risk is there. The best scenario is for two RNs to count at the beginning and end of the day. Narcotics should be checked out to your anesthesia providers and reconciled with an RN at the end of the day. Please see sample forms on *eSupport_Operations_Medication Management_Controlled Substances* if you are an eSupport subscriber.

Q We have a CRNA providing sedation/monitoring intraprocedure. Is it required that there be at least one RN intraprocedure? Is it required that the circulator be an RN or can it be an LPN? We rotate our RNs and LPNs in all positions.

A There should be an RN circulating each case. There are currently 22 states that mandate this so check your state regulations. An LPN does not have the training or expertise to circulate a case. The patient assessment required and the documentation required is outside the scope of an LPN. In some states, LPNs cannot even provide discharge education, so become familiar with your scope. This is not only for the OR, but for pre/post as well. Be sure you ask your Board of Nursing to define what level of supervision is required of LPNs. Some states are specific on this, others are not.
Many nurses are not aware of the responsibilities of RN Circulators. Click the link to view a YouTube video from AORN that does a great job of explaining the role.
http://youtu.be/fbYP65XZvYY

INFECTION CONTROL

Q **We do our pain procedures in the OR. We put a gown over their clothes and when they transfer from the w/c to the table they get their gown all twisted up and in the way. I have read that AORN states that a blanket may be used to cover their clothes but we would need to have a policy on this. However, when they transfer to the table the blanket does not cover their clothes for that moment and I feel that is an infection control breach. This is why we continue to have them wear a gown over their shirt. What are your thoughts?**

A This answer assumes that there are not other ORs where non-pain procedures are concurrently being performed. If so, all patients should change into gowns since you will be in the semi-restricted and restricted areas along with patients whose procedures are not appropriate for any street clothing.

If only these procedures are being performed, a gown for clothing coverage or a blanket is fine to use. Truly, whichever is most convenient for your facility and your patients. Patient's clothes must not be soiled. If so, they should change into a gown. Put shoe covers on their feet and a hat on their head to minimize any cross contamination that may occur.

The key to this process is ensuring that you are using surface disinfectant on all horizontal surfaces in between patients and terminally cleaning the OR at the end of the day.

Q **We have irrigation fluids in a warmer and as they are needed the OR circulator steps out to grab them on an as needed basis. However, this means opening and closing the door to the OR and the State recognized this as an infection control breach. What does other places do?**

A You don't mention where the warmer is located. Since your state considered it an infection control breach, we assume the warmer is in the pre/post area or somewhere outside of the sterile core. While it is true that you want to keep the door closed to the OR and open it a minimal number of times, one of the roles of the circulating RN is to obtain needed supplies. If this occurs frequently, you should consider installing a warmer in the sterile core or in the OR itself.

Q **We have a place designated as a drink area in the clinical setting, but staff members tend to want to have snacks there as well. We say "no", but it's a regular struggle. Can you confirm that a designated place in the clinical area is only meant for drinks?**

A You should not have drinks or food for staff in the clinical area. They need to go to the lounge or other designated non-clinical area, if you don't have a lounge. I agree this is a struggle. When I was an Administrator, I found staff using our linen closet for this since we didn't allow them to have food/drinks at the nursing station. We have all been there! But, for infection control reasons, no food or drink for staff should be in patient care areas.

DOCUMENTATION

Q **What are other ASCs doing with Advance directives and power of attorneys, do you have a copy in patients chart?**

A You should ask your patients to bring a copy of their advance directive if they have one. However, it is not mandatory to have it on the chart, unless your state regulations require it. Either way, be sure to designate that the patient has an advance directive, whether or not they bring a copy for your chart.

Q **Have you used any of the cloud based or digital policy and procedure management systems? There is one approved that cross-references AAAHC standards but I cannot locate that information now. Are these solutions worth the time and money?**

A We do not have any experience or expertise with this. As with anything you are doing that is a new venture, compare prices of 2-3 companies and be sure to talk to references to ensure it is worth your while.

Q Should personnel files contain a copy of the job description itself, or is the job description acknowledgement enough?

A The job description acknowledgement is enough, as long as it mentions the job title.

Q Charts need to be complete in 30 days. What are some suggestions for handling charts that cannot be completed because the anesthesia provider won't be back for 3 months, or the staff person is per diem and unavailable? Is an incident report appropriate for these situations?

A Chart completion can be a challenge. Ensure that this requirement for completion is in your medical staff rules and regulations and that each provider receives a copy upon their initial appointment.

This is to establish the baseline of the expectation.
If you have a provider that comes to your facility only periodically, attempt to have their charts reviewed prior to their leaving the facility for the day or make arrangements for them to return at a certain time to complete their charts.

Ask your medical director to become involved in this process for LIPs.
If you have LIPs who are “repeat offenders” who consistently do not complete this requirement, engage the peer review process. This lets peers discuss the issue with them and provides a mechanism to show improvement or it may impact subsequent appointments.

Ensure your clinical staff knows this is a requirement of their job, whether they are per diem, PT or FT. If they do not complete their charting during their shift, have them complete it when they pick up their check (unless they have direct deposit, of course). If they consistently do not complete their charting, consider not using them and this issue should be reflected on their annual appraisal and competency.

If this is widespread among LIPs and clinical staff, we recommend performing a QI study to dig further into the issue and develop an action plan for improvement.

Q Do we need a policy screening patients about international travel? This is in reference to recent Ebola screenings that are no longer required and potentially Zika?

A For the Zika Virus, the CDC is recommending use of standard precautions, which you should be adhering at all times in any case. Please go to this link for more information: http://www.cdc.gov/mmwr/volumes/65/wr/mm6511e3.htm

Since standard precautions should already be covered in your policies, you would not need a specific policy for international travel. That being said, you should make sure that your communicable disease policies cover what you will do if a patient with a suspected communicable disease comes into your facility and you should have a list of national and state reportable diseases along with the policy for reporting.

Q For Non-TJC-Ophthalmic ASCs is it okay to use the following abbreviations: OD (right eye), OS (left eye), OU (both eyes), LUL (left upper lid), LLL (left lower lid), RUL (right upper lid), RLL (right lower lid). Other abbreviations we use: D/C (discontinue/discharge), NS (normal saline), BLK coffee (black coffee), T3 (Tylenol w/ codeine), AJ (apple juice), GJ (grape juice), HOH (hard of hearing), PCN (penicillin), ASA (aspirin), N/V (nausea, vomiting), RLS (restless leg syndrome), for IVs sites H (hand), W (wrist), AC (antecubital)

A Please reference the ISMP's List of Error-Prone Abbreviations, Symbols, and Dose Designations https://www.ismp.org/tools/errorproneabbreviations.pdf. OD, OS, OU, T3, and d/c are on this list and therefore not recommended. The abbreviations on your list that would be appropriate to use are LUL, LLL, RUL, RLL, NS, PCN, ASA N/V, RLS, and AC. These should all be part of your approved abbreviations list.

SCHEDULING

Q **We are a small 4-surgeon Ophthalmic Surgery Center. Currently each surgeon has a set day to do surgery. Either a whole day or a half-day set for them. These days are set even if they have 3, 10, or 20 cases. It is not profitable for our ASC to have a surgeon scheduled to the ASC for a half or full day when they have 3 cases. Our system is not efficient. Would you have any suggestion of how to improve it? Could block scheduling work?**

A We agree that 3 cases may not be a profitable day. More information is needed to review this issue. The old adage of "you can't manage what you don't measure" fits here.

We recommend you evaluate reports that will give you data you will need to fully evaluate this issue and provide the facts you will need to discuss this issue with your Board. Hopefully your software system allows for easy retrieval of this information.
You currently have block scheduling. Each MD has a block of a ½ day or full day. Run a block utilization report for each physician. Over time, anything less than 75% is fairly inefficient. So, for example, if MD 1 has an allotted block of 8 hours per week, but only uses 4 hours per week on a consistent basis, you should decrease his block time and open ½ day for him instead of a full day.

Run an OR utilization report. Your volume should dictate the hours your OR(s) is open. Depending on your results, you may decide to open your OR(s) a certain number of days per week or per month. You can then back your MD block use time into those days. For example, if your total volume is 60 cases per week on average, you may want to be open only 3 days per week. You may want to allot surgeon time within these three days or offer blocks every other week to a low volume surgeon.

These two reports are a good start in evaluating your needs, as far as OR time.
You should also be tracking salary cost per case and FTEs. Benchmark these numbers against the industry to determine if you have opportunities for improvement. These numbers will most likely be elevated in comparison to the industry if your OR time management is inefficient.

There are many variables that can affect efficiency. Please let us know through the forum if you have further questions or if you would like to talk with a consultant who can go into more detail with you after learning more about your particular facility.

QAPI Committee Meeting
Agenda

Date

Members present: (include in minutes)

Members absent: (include in minutes)

1) Old Business
    a. Review and approval of previous QAPI committee meeting minutes
    b. Other old business, as appropriate

2) New Business
    a. Pharmacy and Therapeutics
        i. Formulary edits
        ii. Pharmacy audits
        iii. Medication Errors
        iv. Other issues
        v. Planned action, as appropriate

    b. Tissue
        i. Pathology issues
        ii. Planned action

    c. Infection Control Report
        i. Results of monthly infection control surveys
        ii. Other issues (hand hygiene results, autoclave issues, etc.)
        iii. Planned action

    d. Medical Records
        i. Results of internal medical records audit
        ii. Other issues
        iii. Planned action

    e. Patient Satisfaction
        i. Patient satisfaction survey results
        ii. Patient complaints/grievances
        iii. Planned action

f. Physical Environment
    i. Safe Environment surveillance results
    ii. Safety issues
    iii. OSHA issues
    iv. Other issues
    v. Planned action

g. Incident Reports
    i. Incident reports review
    ii. Planned action

h. Indicators/Benchmarking (individualize line items below)
    i. Mandatory CMS Indicators
    ii. Mandatory State Indicators, if applicable
    iii. Cancellations
    iv. Complications
    v. Facility Utilization
    vi. Any other indicators
    vii. Benchmarking results
    viii. Planned action

i. QI/PI Studies
    i. PI studies discussion (current and planned)
    ii. Planned action

j. Policies and Procedures
    i. New/revised policies/procedures
    ii. Planned action

k. Other Business (individualize line items below)
    i. Business Office Issues
    ii. Other

***Note: for meeting minutes, it is suggested to write them in a word table format with the following columns:

- Agenda Item
- Discussion (keep this short; no need to go into great detail)
- Action Taken
- Follow up

This format will help keep your minutes short but complete.
Be sure to include attendees and those absent in your meeting minutes.

Overwhelmed by questions like this on a regular basis? **Frustrated** trying to find the answers in a worldwide web of complex regulations? **Tired** of **wasting time** that you just don't have?

…and *still* not an eSupport member?

You owe it to yourself to find out more

For *peace of mind* and **unlimited access** to:

- All of the resources referenced above
- The exclusive eSupport Forum where you can get answers from clinical experts in less than 24 hours
- Sample contracts, forms, and up-to-date policies and procedures
- *Real* survey deficiency reports from facilities nationwide
- Continued Education with CE contact hours for you and your staff
- And more!

Join the community!

Click to Request your FREE web demo today

(855) 777 4272

info@pss4asc.com

PROGRESSIVE eSupport
LIFE SUPPORT FOR YOUR ASC

www.progressivesurgicalsolutions.com/esupport